18/V

SPIRIT OF MAN LECTURE

LOS ANGELES, CA

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C. EVERETT KOOP, MD

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GREETINGS, ETC.

IT IS AN HONOR FOR ME TO BE WITH YOU TODAY, TO JOIN THE RANKS OF THE DISTINGUISHED "SPIRIT OF MAN" LECTURERS. AS YOUR FORMER SURGEON GENERAL, A PUBLIC HEALTH OFFICER CONCERNED ABOUT THE WHOLE HEALTH OF THE WHOLE AMERICAN PEOPLE, I APPLAUD THE COMPREHENSIVE THEME OF THIS LECTURE SERIES.

OUR JUDEO-CHRISTIAN TRADITION VIEWS HUMAN BEINGS AS A BEING A SOUL, POSSESSING A BODY AND HAVING TRINITY, [redacted] A SPIRIT.

PHYSICIANS AND OTHER HEALTHCARE WORKERS KNOW WELL THE BODY AND THE SOUL, BUT SOMETIMES THE SPIRIT OF MAN SUFFERS FROM NEGLECT, FROM MALNUTRITION.

I AGREE WITH THE PSALMIST: "WE ARE FEARFULLY AND WONDERFULLY MADE." WE NEED TO NOURISH AND EXERCISE OUR ENTIRE BEINGS, BODY, SOUL, AND SPIRIT.

I OFFER MY REMARKS TODAY IN THE SPIRIT OF CALDWELL ESSELSTYN, SHARING HIS ASPIRATION THAT SOCIETY'S MOST PRESSING MEDICAL CARE PROBLEMS WOULD BE ADDRESSED NOT ONLY BY OUR SCIENTIFIC EXPERTISE, BUT ALSO BY A NOBILITY OF SPIRIT.

TODAY I'D LIKE TO TALK TO YOU ABOUT SOMETHING THAT WE ALL ONCE WERE.... SOMETHING TO WHICH WE ALL LOOKED FORWARD....SOMETHING TO WHICH MANY OF US LOOK BACK WITH FOND MEMORIES....BUT SOMETHING WE DIDN'T LIKE ALL THAT MUCH AS IT HAPPENED.

I'D LOVE TO KNOW WHAT WENT THRU YOUR INDIVIDUAL MINDS AS I SAID THAT. I SUSPECT MOST OF YOU GUESSED WRONG. I WISH TO ADDRESS

[redacted] THAT MAGICAL, NECESSARY, TROUBLED PHASE OF LIFE WE CALL ADOLESCENCE.

HISTORICALLY SPEAKING, ADOLESCENTS ARE A RATHER RECENT INVENTION. OF COURSE, THERE HAVE ALWAYS BEEN PEOPLE IN THE AGE BRACKET WHERE WE NOW FIND ADOLESCENTS --FROM ABOUT TWELVE UNTIL THE EARLY TWENTIES-- BUT UNTIL RECENTLY SOCIETY HAD A PLACE FOR ONLY TWO GROUPS: CHILDREN AND ADULTS.

YOU WERE EITHER ONE OR THE OTHER. AND SOMETIMES THE ADVERSITIES OF LIFE FORCED CHILDREN TO GROW UP VERY FAST INDEED.

EVEN IF WE REPLACE THE TRADITIONAL ADULT/CHILD DIVISION OF SOCIETY BY A GENERATIONAL ONE, WE FIND NO ROOM FOR ADOLESCENTS.

TWO WEEKS AGO WHEN I GAVE THE COMMENCEMENT ADDRESS AT VASSAR COLLEGE, I LOOKED BEYOND THE YOUNG GRADUATES SEATED BEFORE ME, TO THE AUDIENCE IN WHICH I WAS PLEASED TO SEE A LOT OF GREY HEADS. I SAID THAT I WAS DELIGHTED TO SEE SO MANY GRANDPARENTS THERE, ALONG WITH PARENTS AND CHILDREN..... BECAUSE MOST OF US SPEND OUR LIVES IN 3-GENERATIONAL WORLDS.

AS WE GO THROUGH LIFE WE CHANGE PLACES IN THAT 3-TO GENERATIONAL WORLD. AND IT DOESN'T SEEM TAKE LONG FOR US TO GO FROM ONE GENERATION TO ANOTHER.

I TOLD THOSE YOUNG GRADUATES THAT IT SEEMED LIKE ONLY YESTERDAY WHEN I WAS RUNNING AROUND THE VASSAR CAMPUS AS A DARTMOUTH BOY, VISITING THE VASSAR GIRL WHO WOULD BECOME MY WIFE. NOW MY WIFE AND I HAD RETURNED, BOTH WITH GREY HAIR, BUT I WARNED THEM THAT IT WOULDN'T BE LONG BEFORE [redacted] THEY WERE THE ONES WITH THE GREY HAIR.

I REMINDED THE YOUNG GRADUATES, THOSE CHILDREN, THOSE YOUNG ADULTS, THOSE ADOLESCENTS, THAT THEY MUST ALWAYS REMEMBER THAT WE ALL NEED THE [redacted] OTHER TWO GENERATIONS....AND ARE NEEDED BY THEM.

BUT EVEN IN A THREE-GENERATIONAL VIEW OF SOCIETY -- CHILDREN, PARENTS, GRANDPARENTS-- IT IS HARD TO SEE WHERE ADOLESCENTS FIT IN.

PERHAPS THEY BEGAN TO CARVE A PLACE FOR THEMSELVES AT THE BEGINNING OF THIS CENTURY, OR AS LATE AS THE 1920S, WHEN COMPULSORY SECONDARY EDUCATION STRETCHED OUT THEIR CHILDHOOD, CHANGED THEM, PERHAPS FROM CHILDREN TO YOUNGSTERS.

BUT IT WASN'T UNTIL AFTER WORLD WAR II, --THIS DEVELOPMENT WAS ARTIFICIALLY POSTPONED, FIRST BY THE GREAT DEPRESSION AND THEN BY THE SECOND WORLD WAR--- WHEN IN THE 1950S MORE AND MORE OF THESE YOUNGSTERS HAD DISPOSABLE INCOME, WHEN THEY WERE TARGETED BY ADVERTISERS, WHEN THEY BEGAN TO DEVELOPE THEIR OWN MUSIC, LIFE STYLES, AND "YOUTH CULTURE"...IT WASN'T UNTIL THEN THAT WE BEGAN TO HEAR A LOT ABOUT TEENAGERS.

AND WE ALSO BEGAN TO HEAR ABOUT THE PARTICULAR PROBLEMS OF ADOLESCENCE.

SINCE THE CREATION OF A DISTINCT AGE --OR CULTURE-- OF ADOLESCENCE WE HAVE SEEN TWO OTHER DEVELOPMENTS.

FIRST, A LENGTHENING OF THE ADOLESCENT PHASE OF LIFE, THROUGH ON ONE HAND THE CREATION OF MORE ADULT OPPORTUNITIES FOR SOME, THOSE WHO ATTEND COLLEGE AND EVEN GRADUATE SCHOOL FOR YEARS BEFORE ENTERING THE ADULT WORKFORCE,

ON THE OTHER HAND,

AND, IRONICALLY, THROUGH THE ELIMINATION OF MORE ADULT OPPORTUNITIES FOR OTHERS, THE HIGH SCHOOL DROP-OUTS, LANGUISHING IN CHRONIC ADOLESCENT UNEMPLOYMENT.

SO, WE PRODUCE MORE AND MORE ADOLESCENTS, WE KEEP THEM IN THAT PHASE OF LIFE LONGER AND LONGER, BUT WE OFFER THEM LESS AND LESS, AND STILL DON'T KNOW WHERE THEY "FIT IN".

NOT REALLY A GENERATION, NOT REALLY A PART OF OTHER GENERATIONS, THEY SUFFER FROM A STRANGE MIXTURE OF INDULGENCE AND NEGLECT.

SOCIETY CRITICIZES ADOLESCENTS FOR HAVING NO EXPECTATIONS, BUT THEN SOCIETY HAS NOT CONVEYED TO THEM WHAT IT EXPECTS OF THEM.

THERE ARE MANY CRACKS IN OUR SOCIETY, AND ADOLESCENTS ARE PRONE TO FALL THROUGH THEM.

ADDED TO ALL THESE PROBLEMS STEMMING FROM AN UNCERTAIN PLACE IN OUR SOCIETY, MOST ADOLESCENTS, AT ONE TIME OR ANOTHER, SUFFER REAL AND UNIQUE PROBLEMS IN HEALTH.

I IMAGINE WE'VE ALL BEEN AROUND HOSPITALS ENOUGH, AS PATIENTS, VISITORS, OR HEALTHCARE WORKERS, TO HAVE OUR BLOOD RACE A LITTLE FASTER WHEN WE HEAR THE WORDS "CODE BLUE".

"CODE BLUE", TWO SHORT WORDS THAT MEAN THAT A LIFE IS ABOUT TO BE CUT SHORT.

"CODE BLUE" SIGNALS A LIFE-THREATENING SITUATION, AND SUMMONS ALL THE RIGHT PEOPLE TO THE RIGHT PLACE AT THE RIGHT TIME....TO SAVE THAT LIFE.

"CODE BLUE" IS THE PHRASE USED RECENTLY BY A NATIONAL COMMISSION ON ADOLESCENT HEALTH --ON WHICH I SERVE AS CHAIRMAN OF THE NATIONAL SAFE KIDS CAMPAIGN-- TO SIGNAL THE CURRENT CRISIS IN ADOLESCENT HEALTH.

"CODE BLUE" IS THE URGENT CRY WE MUST HEED TO MEET THIS DEBILITATING AND YET MOSTLY HIDDEN NATIONAL EMERGENCY.

THIS ENDANGERED AGE GROUP IS BUT A FEW YEARS FROM HAVING A PROFOUND RESPONSIBILITY FOR THE REST OF US, A PROFOUND IMPACT ON EACH OF US.

IN A FEW YEARS THEY WILL BECOME, NOT ONLY THE LEADERS OF THIS NATION, BUT ALSO THE PARENTS OF THE NEXT GENERATION, THE PARENTS OF THE NEXT WAVE OF ADOLESCENTS.

UNLESS WE RESPOND CORRECTLY TO THE CURRENT CRISIS IN ADOLESCENT HEALTH WITH COMPASSION, URGENCY AND SKILL, THE PROBLEMS FOR OUR SOCIETY WILL NOT ONLY ADD UP, THEY WILL MULTIPLY.

AT THE OUTSET WE NEED TO DISABUSE OURSELVES OF SOME COMMON MISCONCEPTIONS.

FIRST, WE MUST PUT ASIDE THE NOTION THAT ADOLESCENCE IS A TIME OF NATURAL GOOD HEALTH, A TIME WHEN CHILDREN BLOSSOM BEAUTIFULLY INTO YOUNG ADULTS, A TIME OF HIGH ENERGY AND WELL-BEING.

NOT TOO LONG AGO, ON ONE OF OUR MOST POPULAR TV PROGRAMS, THE BILL COSBY SHOW, THE FATHER, AN AGING TRACK STAR --LIKE COSBY HIMSELF WHO PLAYED THE ROLE-- JOKINGLY TOLD HIS WIFE HE HAD SEEN SOMETHING BEAUTIFUL. "WHAT WAS IT?" SHE ASKED. "NINETEEN," HE SAID..... HE HAD STOPPED TO WATCH A NINETEEN YEAR-OLD RUNNER SPRINTING AROUND THE TRACK, AND THAT CONJURED UP AN IMAGE OF PERFECT HEALTH AND ENERGY. THAT'S NOT THE WAY IT IS FOR MANY OF AMERICA'S NINETEEN YEAR-OLDS.

SECOND, WE MUST SET ASIDE THE ASSUMPTION THAT ADOLESCENT HEALTH PROBLEMS ARE LIMITED TO COMMUNITIES PLAGUED WITH HIGH RATES OF CRIME AND POVERTY.

NO, IT IS IN ALL COMMUNITIES, IN EVERY NEIGHBORHOOD ACROSS THE COUNTRY, THAT WE FIND PROBLEMS AFFECTING ADOLESCENT HEALTH.

TRUE, MANY OF THESE PROBLEMS DO STEM FROM POVERTY.

BUT AFFLUENCE IS NO PROTECTION.

IN FACT, THERE ARE A HOST OF ADOLESCENT HEALTH PROBLEMS AFFLICTING THE CHILDREN OF AFFLUENCE, THE OVERLY-DRIVEN CHILDREN OF DEMANDING MIDDLE CLASS PARENTS: AFFLICTIONS LIKE ANOREXIA NERVOSA, BULIMIA, AND SIMILAR DISORDERS.

A GENERATION OR TWO AGO, THE CHIEF THREATS TO THE HEALTH OF AMERICA'S ADOLESCENTS LAY IN THE VARIETY OF INFECTIOUS DISEASES TO WHICH THEY MIGHT FALL VICTIM. BUT AS MEDICAL SCIENCE HAS MADE GREAT STRIDES IN ERADICATING OR CONTROLLING MANY OF THOSE INFECTIOUS DISEASES, THE HEALTH OF OUR ADOLESCENTS HAS NOT SHOWN THE EXPECTED IMPROVEMENT.

IN FACT, ADOLESCENTS ARE THE ONE GROUP OF AMERICAN SOCIETY WHOSE HEALTH HAS NOT SHOWN IMPROVEMENT OVER THE LAST 70 YEARS.

OUR CHALLENGE TODAY STEMS FROM THE NATURE OF THE ADOLESCENT HEALTH PROBLEMS.

NO LONGER INFECTIOUS OR OTHER "PHYSICAL DISEASES" LINGERING OUT THERE TO PREY UPON UNSUSPECTING AND INNOCENT VICTIMS, THE THREATS TO ADOLESCENT HEALTH LIE IN THE REALM OF BEHAVIORAL PROBLEMS.

IT IS WHAT ADOLESCENTS CHOOSE TO DO THAT BRINGS THEM TO THE HEALTH PROBLEMS THAT THEY SUFFER.

THE LIST IS ALL TOO FAMILIAR:

DRINKING, SMOKING, AIDS, PREGNANCY, SEXUALLY TRANSMITTED DISEASES, VIOLENCE, SUICIDE.

TRUE, SOME OF THESE PROBLEMS MAY TECHNICALLY OR LEGALLY HAVE A PHYSICAL OR BIOLOGICAL BASIS AND HENCE BE TERMED A DISEASE, BUT THEIR DANGER LIES IN THEIR LINK WITH ADOLESCENT BEHAVIOR.

THIS OF COURSE MAKES TREATMENT AND PREVENTION DIFFICULT AND COMPLICATED, BECAUSE HEALTH PROBLEMS STEMMING FROM BEHAVIOR INVOLVE NOT ONLY PHYSICAL ASPECTS, BUT ALSO THE EMOTIONAL, SOCIAL, AND EVEN ECONOMIC AND POLITICAL DIMENSIONS AS WELL.

To be sure, [redacted], THIS IS A FACTOR AFFECTING THE HEALTHCARE OF THE ENTIRE NATION – – THE BLURRING OF PURE MEDICINE AND THE SOCIO-ECONOMIC MILIEU IN WHICH IT IS PRACTICED.

A YEAR OR TWO AGO I WAS ASKED TO TAKE GRAND ROUNDS IN PEDIATRICS AT A MAJOR TEACHING HOSPITAL.

WHEN I WAS FINISHED LISTENING TO THREE CASES, HAVING DONE THE BEST I COULD WITH THE PROBLEMS, I HAD TO REMIND THE RESIDENT STAFF, WHEN THE AUDIENCE LEFT, THAT I WOULD NOT HAVE GOTTEN AWAY WITH PRESENTING THOSE THREE PATIENTS THE WAY THEY JUST DID WHEN I WAS IN THEIR POSITION BECAUSE THEY HAD NOT PRESENTED STRICTLY MEDICAL PROBLEMS:-- WHAT THEY HAD PRESENTED TO ME WERE SOCIO-ECONOMIC PROBLEMS THAT HAD COME TO THE HOSPITAL BECAUSE THE PATIENT HAD AN ILLNESS.

THE PROBLEMS OF ADOLESCENT HEALTH OFTEN CAN BE TRACED TO THE GROWING GAP BETWEEN ADULTS AND ADOLESCENTS IN COMMUNICATION AND UNDERSTANDING.

ADOLESCENTS SEEM TO THINK DIFFERENTLY.

THEY SEEM TO BE INHERENT RISK-TAKERS.

ALL EVIDENCE TO THE CONTRARY, THEY HAVE A SENSE THAT THEY ARE IMMORTAL.

SO THEY HAVE AN SEEMINGLY INSTINCTIVE RESPONSE TO TUNE OUT ANY ADMONITION THAT BEGINS WITH "DON'T".

I SHOULD SAY AT THIS POINT THAT MY CONCERN ABOUT THE PROBLEMS OF ADOLESCENT HEALTH COMES DIRECTLY FROM MY TWO MEDICAL CAREERS.

AS YOUR SURGEON GENERAL, AS THE NATION'S CHIEF PUBLIC HEALTH OFFICER FOR EIGHT YEARS, IT BECAME APPARENT TO ME THAT MANY OF THE PUBLIC HEALTH ISSUES I DEALT WITH -- SMOKING, AIDS, ALCOHOL, AND SO FORTH-- HAD AN ESPECIALLY ALARMING ADOLESCENT DIMENSION.

AND, FOR FORTY YEARS BEFORE THAT, AS A PEDIATRIC SURGEON, I BEGAN TO HAVE REAL CONCERNS ABOUT WHAT WOULD HAPPEN TO THE TINY INFANTS ON WHOM I OPERATED... WHEN THEY BECAME ADOLESCENTS. IT GRIEVED ME TO THINK HOW I AND MY ASSOCIATES CORRECTED LIFE-THREATENING DEFECTS IN THE FIRST HOURS OR DAYS OF LIFE, ONLY TO HAVE THAT PRECIOUS LIFE IMPERILED BY ADOLESCENT BEHAVIORAL HEALTH PROBLEMS.

AND THOSE PROBLEMS ARE ALL TOO REAL.

STATISTICS DON'T TELL THE STORY, BUT EVERY SPIRIT OF MAN LECTURE SHOULD HAVE A FIRM DATA BASE AS A FOUNDATION FOR ITS CALL TO ACTION. SO, A FEW COMPARISONS, A FEW NUMBERS:

IN 1965 THERE WERE ABOUT 4 CASES OF GONORRHEA AND SYPHILIS FOR EVERY 1,000 AMERICAN ADOLESCENTS.

IN 1985 THAT NUMBER HAD CLIMBED TO 12 REPORTED CASES PER 1,000, WITH SO MANY MORE UNREPORTED THAT THE CENTERS FOR DISEASE CONTROL ESTIMATED THAT EACH YEAR 2.5 MILLION ADOLESCENTS CONTRACT A SEXUALLY TRANSMITTED DISEASE.

IN 1965, 16.7 OUT OF 1,000 UNMARRIED GIRLS AGED 15–19 GAVE BIRTH.

TWENTY YEARS LATER, 31.6 PER 1,000.

AMERICA'S TEENAGE PREGNANCY RATE IS 1 TEENAGE GIRL OUT OF EVERY 10, A RATE DOUBLE THAT OF ANY OTHER INDUSTRIALIZED SOCIETY.

IN THE 1950S LESS THAN 5% OF YOUNG PEOPLE HAD TAKEN AN ILLICIT DRUG;

BY 1987, THE NATIONAL ADOLESCENT STUDENT HEALTH SURVEY INDICATED, 77% OF EIGHTH GRADERS AND 89% OF TENTH GRADERS HAVE USED ALCOHOL;

15% OF EIGHTH GRADERS AND 35% OF TENTH GRADERS HAVE USED MARIJUANA;

AND AMONG THE CLASS OF 1987, 5.6% HAD USED

CRACK-COCAINE.

IN REAL NUMBERS, STANDING FOR REAL PEOPLE, THAT MEANS

MORE THAN 3.5 MILLION YOUNG TEENS (12-17) HAVE USED

MARIJUANA,

AND OF THESE ONE THIRD ARE REGULAR USERS.

OVER HALF A MILLION HAVE USED COCAINE, AND HALF OF THESE

HAVE BECOME REGULAR USERS, OR I SHOULD SAY ABUSERS.

SADLY, MANY TEENAGERS DON'T SURVIVE THEIR TEENS.

OVER 50% OF HIGH SCHOOL SENIORS GET DRUNK AT LEAST ONCE A MONTH, AND THE DEADLY COMBINATION OF DRINKING AND DRIVING RANKS NUMBER ONE AS A KILLER OF ADOLESCENTS.

TEN TEENAGERS ARE KILLED EVERY DAY IN ALCOHOL-RELATED TRAFFIC FATALITIES.

SUICIDE RANKS SECOND AMONG KILLERS OF TEENS, WITH 10 PERCENT OF TEENAGE BOYS AND 18 PERCENT OF TEENAGE GIRLS ATTEMPTING SUICIDE. AND WHILE IT IS TRUE THAT THE BLACK COMMUNITY SUFFERS A DISPROPORTIONATE BURDEN OF SOME ADOLESCENT HEALTH PROBLEMS, IT IS IN THE WHITE POPULATION THAT SUICIDE TAKES IT GREATEST TOLL.

HOMICIDE, THE LEADING CAUSE OF DEATH AMONG 15–19 YEAR OLD BLACKS, CLAIMS 26.6 PER 100,000.

PART OF THAT TERRIBLE PROBLEM CAN BE TRACED TO THE 135,000 AMERICAN TEENAGERS WHO CARRY GUNS TO SCHOOL EACH DAY.

CRIME AMONG TEENS HAS LED TO A THIRTY-FOLD INCREASE IN THE NUMBERS ARRESTED SINCE 1960.

THE KILLER EPIDEMIC OF AIDS HAS BECOME A SERIOUS THREAT TO OUR ADOLESCENT POPULATION. AS OF APRIL 1990, THERE HAVE BEEN 2250 CASES OF AIDS FROM BIRTH TO 13 YEARS OF AGE.

THERE HAVE BEEN 513 CASES IN TEENAGERS 13 TO 19 YEARS OF AGE. 402 MALES - 111 females. THOSE FIGURES ARE MISLEADING ~~THAT IS A MISLEADING FIGURE~~. WITH THE LONG INCUBATION PERIOD FOR HIV INFECTION, LOOK TO THE PREVALENCE OF AIDS IN THE 20–30 YEAR GROUP TO GET AN IDEA OF WHEN HIV INFECTION TAKES PLACE – IN THE TEEN YEARS.

APRIL

TOTAL 132510

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1-5	968	895
5-12	258	137
13-19	402	111

MORE THAN 2 MILLION ADOLESCENTS SUFFER ABUSE AND NEGLECT REPORTED TO THE AUTHORITIES, BUT PROBABLY AN EQUAL NUMBER GO UNREPORTED.

AND, OVER HALF A MILLION TEENS ARE RUNAWAYS, ANOTHER HALF A MILLION AREN'T IN THEIR OWN HOMES BECAUSE THEY ARE PLACED IN FOSTER HOMES OR OTHER INSTITUTIONS.

ALL IN ALL

42 MILLION ADOLESCENTS HAVE SEVERE PROBLEMS.

AND ALL OF THESE ALARMING FIGURES ARE SPREADING, THEY ARE SPREADING TO YOUNGER AND YOUNGER TEENS, TO CHILDREN.

IN EVERY STATE THE AGE AT WHICH CHILDREN BECOME INVOLVED IN RISKY BEHAVIOR --DRINKING, SMOKING, SEX, GANGS-- GETS LOWER EACH YEAR.

AN EXAMPLE: IN 1965 ONLY 3% OF GIRLS WERE SEXUALLY ACTIVE BEFORE THEIR 16TH BIRTHDAY, BUT NOW OVER 15% ARE.

LOOKING TOWARD THE OLDER YEARS, WE SEE THE EFFECT OF THESE BEHAVIOR-LINKED PROBLEMS LASTS LONGER AND LONGER INTO ADULT LIFE.

THE BEST, THE WORST, EXAMPLE, OF COURSE IS AIDS. UNPROTECTED SEX AND/OR IV DRUG USE CAN READILY LEAD TO HIV INFECTION THAT LASTS THE REST OF A LIFE NOW CUT SHORT BY MANY DECADES. OTHER STDS CAN LEAD TO LONG-LASTING HEALTH PROBLEMS AND EVEN STERILITY.

CRACK COCAINE CAN MAINTAIN ITS GRIP ON AN ENTIRE LIFE,

AND ALSO REACH OUT TO RUIN LIVES JUST STARTED, AS THE

ALARMING INCREASE IN BABIES BORN TO COCAINE-ABUSING

MOTHERS --375,000 OF THESE

PATHETIC INFANTS LAST YEAR.

TRAGICALLY, ONE OF THE MOST COMMON RESULTS OF THIS SELF-DESTRUCTIVE BEHAVIOR IS TO PASS IT ON ALL THE MORE QUICKLY TO THE NEXT GENERATION.

IT IS OFTEN THESE PROBLEM-RIDDEN ADOLESCENTS WHO TEND TO BECOME PARENTS AT A YOUNGER AGE, AND THEN TO START THE CYCLE AGAIN.

WE KNOW THAT ABUSED CHILDREN, OFTEN OF ABUSED PARENTS, BECOME THEMSELVES ABUSERS OF THE NEXT GENERATION.

ALCOHOLIC PARENTS PASS ON BEHAVIOR PATTERNS, AND WE NOW SUSPECT, EVEN GENETIC TENDENCIES, ENCOURAGING ALCOHOL ABUSE IN THEIR CHILDREN.

AS WITH ANY PROBLEM, WE'D LIKE TO SORT OUT THE CAUSES AND EFFECTS, FOCUS ON THE CAUSES, AND THEN SOLVE THE PROBLEMS.

BUT IT IS NOT THAT EASY.

UNFORTUNATELY, LISTS OF CAUSES AND SYMPTOMS SEEM TO BE INTERCHANGEABLE.

I'LL READ OFF A FEW ITEMS FROM LISTS OF FACTORS RELATED TO ADOLESCENT HEALTH PROBLEMS. SOME OF THESE WERE LISTED AS CAUSES, SOME AS SYMPTOMS. BUT I'LL MIX THEM UP AS I READ THEM, AND AS I GO, YOU WILL SEE HOW DIFFICULT IT IS TO DECIDE WHETHER A CERTAIN ITEM IS A CAUSE OR A RESULT.

~~SYMPTOM.~~

SUBSTANCE ABUSE, UNSTABLE FAMILIES, AIDS, EARLY PREGNANCIES, POOR PARENTING SKILLS, EMOTIONAL DYSFUNCTION, POOR PEDIATRIC CARE, ETHNIC HOSTILITY, POVERTY, VIOLENT BEHAVIOR, POOR SELF IMAGE, POOR MATERNAL HEALTH CARE, EDUCATIONAL FAILURE, LONELINESS, STRESS....

WELL, YOU GET THE PICTURE.

AT THE TOP OF THE LIST OF CHRONIC PROBLEMS, FINDING ITS CENTRAL PLACE IN THE CIRCLE OF CAUSE AND EFFECT IS POVERTY .....

THE ALARMING AND RAPID INCREASE IN POVERTY, ESPECIALLY AMONG CHILDREN.

TWENTY FIVE PERCENT OF THE ADOLESCENTS OF THE 1990S ARE ALREADY LIVING IN POVERTY.

THAT REFLECTS A NATIONAL POVERTY RATE TWO OR EVEN THREE TIMES HIGHER THAN THAT OF OTHER INDUSTRIALIZED SOCIETIES.

ONE HALF OF ALL BLACK AND HISPANIC CHILDREN UNDER 6 ARE POOR.

IN THE LAST FIVE YEARS, THE NUMBER OF FAMILIES IN POVERTY HAS GROWN BY FORTY PERCENT, WITH FAMILIES BECOMING THE FASTEST GROWING SEGMENT OF THE HOMELESS POPULATION.

[HERE, CEK CONVERSATION WITH HOMELESS KIDS.]

ALL THIS AMOUNTS TO POORER HOUSING, UNSAFE LIVING ENVIRONMENTS, ... POORER HEALTH FOR AMERICA'S ADOLESCENTS.....

MORE STRESS ON FAMILIES.

AND THIS COMES AT A TIME WHEN FAMILIES ARE LESS ABLE TO BEAR STRESS.

THERE ARE SIGNIFICANT CHANGES IN TRADITIONAL FAMILY STRUCTURES AND ROLES.

THE AMERICAN FAMILY, AS WE HAVE KNOWN IT EARLIER IN THIS CENTURY, HAS FALLEN APART.

IN 1965 11.3% OF AMERICAN CHILDREN LIVED IN SINGLE-PARENT HOMES. BY 1987 21% OF AMERICANS UNDER 18 LIVED IN HOMES WITH A SINGLE PARENT.

DIVORCE, REMARRIAGE, DESERTION BY ONE PARENT OR THE OTHER.... ALL THIS HAS TORN FAMILIES APART, AND LEAD TO THE RESTRUCTURING OF FAMILIES IN NEW, SKELETAL, AND OFTEN DYSFUNCTIONAL FORMATIONS.

GENERATIONAL LINES ARE BLURRED BECAUSE GRANDMOTHER, MOTHER AND GRANDCHILD ALL HAVE CHILDREN BEING RAISED TOGETHER.

PARENTS INCREASINGLY DON'T ASSUME PARENTAL FUNCTIONS. IN SOME CASES THIS IS BECAUSE THEY ARE TOO YOUNG, - CHILDREN HAVING CHILDREN, BUT IN OTHER CASES THE PARENTS MANIFEST ILL-HEALTH, PERSONAL EMOTIONAL TRAUMA, AND THE INABILITY, OR EVEN UNWILLINGNESS TO COPE.

AS THE MIDDLE CLASS [redacted] SHRINKS, LARGER NUMBERS OF FAMILIES HAVE FEWER RESOURCES FOR SURVIVAL.

AND AS NUCLEAR FAMILIES BREAK DOWN, THE NEXT LEVEL OF SUPPORT --EXTENDED FAMILIES AND NEIGHBORHOODS-- SUFFER SIMILAR DISINTEGRATION IN A MORE URBANIZED, MORE MOBILE, MORE ANONYMOUS AMERICAN CULTURE.

THIS MEANS THAT WITH EACH PASSING YEAR, AMERICAN CHILDREN AND ADOLESCENTS HAVE LESS AND LESS CONTACT WITH ADULTS.

PARENTS WORK, RELATIVES AND NEIGHBORS MOVE AWAY OR ARE DISINTERESTED, YOUNGSTERS ARE LEFT ALONE.

THE AVERAGE CHILD SPENDS LESS THAN AN HOUR A DAY WITH HER OR HIS MOTHER, AND LESS THAN 5 MINUTES WITH THE FATHER. AND MANY DON'T HAVE ONE PARENT AROUND AT ALL.

ONLY 9% OF CHILDREN IN THE U.S. LIVE WITHIN WALKING DISTANCE OF GRANDPARENTS

EVEN WHEN BOTH PARENTS ARE PRESENT WE SEE AN ALARMING TENDENCY TO PASS THE BUCK OF PERSONAL RESPONSIBILITY.

PARENTS LEAVE TO THE SCHOOLS THE ENTIRE TASK OF EDUCATING THEIR CHILDREN, WHEN NOT LONG AGO PARENTS CLAIMED THE EDUCATION OF THEIR CHILDREN TO BE THEIR PRIVILEGE AND OBLIGATION, EVEN IF SHARED WITH THE SCHOOLS.

CHILDREN LIVE IN THEIR OWN CULTURE, REMOTE FROM ADULTS, DOMINATED ONE YEAR BY TRANSFORMER TOYS, THE NEXT BY CABBAGE PATCH DOLLS, THE NEXT BY TEENAGE MUTANT NINJA TURTLES.

THEY LEAD LIVES DETACHED FROM PARENTAL CONCERN OR INTEREST, TURNING TO PEERS FOR THE GUIDANCE OR EVEN PLAYFUL COMPANIONSHIP THAT PARENTS AND GRANDPARENTS USED TO PROVIDE.

INTO THE VACUUM CREATED BY THE ABSENCE OF ADULTS HAVE MOVED TELEVISION, RADIO, MOVIES, AND VIDEOS, OFTEN WITH A CONSTANT MESSAGE OF SEX, VIOLENCE, AND GREED.

RELIGIOUS TEACHING AND ETHICAL VALUES, IF THEY ARE INSTILLED AT ALL, ARE NOW LEFT TO CHURCH OR SYNAGOGUE. . . OR MTV.

AS WE MOVE INTO THE LAST DECADE OF THE TWENTIETH CENTURY, OUR NATION HAS YET TO ENACT A NATIONAL YOUTH AGENDA THAT

ADDRESSES THE NEEDS OF ADOLESCENTS COMPREHENSIVELY. EXISTING SERVICE DELIVERY SYSTEMS DO NOT FUNCTION IN WAYS THAT CHERISH AND PROVIDE FOR ADOLESCENTS AND THEIR FAMILIES. IT IS TIME TO RE-EXAMINE THE WAYS IN WHICH WE LOOK AT ADOLESCENTS AND THEIR SPECIAL HEALTH PROBLEMS -- TO REALLOCATE RESOURCES AND TO REDESIGN SERVICE DELIVERY SYSTEMS IN WAYS THAT HELP ALL OF OUR YOUNG PEOPLE, AND THEIR FAMILIES, COPE WITH THE CHALLENGES ASSOCIATED WITH BECOMING WELL-EDUCATED AND HEALTHY CITIZENS.

WHAT CAN WE DO?

WELL, I'VE GIVEN THIS A LOT OF THOUGHT, ESPECIALLY IN THE LAST FEW WEEKS WHEN I HAVE SPENT SO MUCH TIME WITH ADOLESCENTS, INTERVIEWING THEM IN CONNECTION WITH MY COMING NBC TV PRIMETIME SPECIAL ON ADOLESCENT HEALTH.

I'LL MAKE A FEW SUGGESTIONS, BASED UPON THE EYE-OPENING FILMING OF THE LAST FEW WEEKS, BASED UPON MY YEARS AS A SURGEON OF CHILDREN AND ADOLESCENTS, AND BASED UPON MY EXPERIENCE AS YOUR SURGEON GENERAL.

IN THAT LAST CAPACITY, ALTHOUGH I MAY HAVE RECEIVED PUBLIC ATTENTION FOR MY EFFORTS AGAINST AIDS, SMOKING, AND DRUNK DRIVING, I TAKE THE GREATEST SATISFACTION FOR AN INITIATIVE I WAS PRIVILEGED TO LEAD THAT REDESIGNED THE WAYS IN WHICH CHILDREN WITH SPECIAL HEALTH NEEDS -- SOME CALLED THEM HANDICAPPED CHILDREN-- COULD TAKE ADVANTAGE OF THE TANGLED WEB OF HEALTHCARE AND SOCIAL SERVICE AGENCIES THAT MIGHT HELP THEM.

THOSE OF US INVOLVED IN THIS INITIATIVE FOR SPECIAL NEEDS CHILDREN WANTED TO MAKE SURE THE SERVICES WERE PLANNED AROUND THE NEEDS OF THE PEOPLE WHO NEEDED THEM, RATHER THAN FORCING THE PEOPLE TO ADAPT TO THE SERVICES.

WE NEED THE SAME APPROACH FOR ADOLESCENT HEALTH PROBLEMS.

A FEW SIMPLE CONCEPTS SHOULD GUIDE US.

ALL OUR EFFORTS SHOULD BE:

FAMILY-CENTERED

COMMUNITY-BASED

CULTURALLY SENSITIVE

COORDINATED

CONFIDENTIAL

ADEQUATELY FINANCED.

FIRST, FAMILY-CENTERED:

EVEN THOUGH THE BELEAGUERED AMERICAN FAMILY IS OFTEN UNLIKE THAT IDEAL FAMILY OF THE STORY BOOKS, WE NEED TO DEAL WITH THE FAMILIES OF ADOLESCENTS, IN THEIR VARIOUS PERMUTATIONS, THE WAY WE FIND THEM, NOT THE WAY WE WOULD WISH THEM TO BE.

EVEN THOUGH FRAGMENTED, THE FAMILY IS THE CONTINUOUS PRESENCE IN THE LIFE OF THE ADOLESCENT.

FAMILIES, EVEN IN UNUSUAL FORMS, SHOW A STEELY RESILIENCE. IN WHATEVER SERVICES WE OFFER THE ADOLESCENT, WE MUST INCLUDE THE FAMILY. IN THE DEVELOPMENT AND APPLICATION OF POLICIES THAT AFFECT ADOLESCENT HEALTH CARE. SERVICES MUST BE FLEXIBLE AND RESPONSIVE TO FAMILIES.

WE NEED TO VIEW FAMILIES AS PRIMARY CARE PROVIDERS, AND GIVE THEM THE INFORMATION AND SUPPLIES THEY NEED TO DO THIS JOB.

WE NEED TO PAY HEED TO THE SINGLE PARENT FAMILIES OR AGGREGATE FAMILIES.

IF WE FIND FAMILIES WEAK, WE NEED TO STRENGTHEN THEM. WE NEED TO STRENGTHEN PARENTING SKILLS, REMEMBERING THAT IN SOME DYSFUNCTIONAL FAMILIES THE PARENT ROLE MAY BE ASSUMED BY AN OLDER SIBLING OR EVEN A SURROGATE ADULT.

FURTHERMORE, OUR CONCERN FOR FAMILIES MUST ENCOMPASS AN AFFIRMATION OF BASIC VALUES. HEALTH IS A MATTER OF THE SPIRIT AS WELL AS THE BODY. PROVISION OF A SPIRITUAL, A RELIGIOUS DIMENSION AMONG THE SERVICES OFFERED ADOLESCENTS AND THEIR FAMILIES WILL REAP LASTING REWARDS.

OUR CONCERN FOR ADOLESCENTS MUST BE

CULTURALLY SENSITIVE:

SERVICES NEED TO BE SENSITIVE TO DIFFERENT CULTURAL VALUES AND CUSTOMS. FOR EXAMPLE, MORE THAN 80% OF CHILDREN WITH HIV INFECTION ARE BLACK OR HISPANIC. SERVICES MUST FOCUS ON THE STRENGTHS AND NEEDS OF THESE GROUPS. MINORITY LEADERS SHOULD BE CENTRAL IN PLANNING AND STARTING SYSTEMS OF SERVICES FOR CHILDREN AND THEIR FAMILIES.

EVEN AFTER A GENERATION OF LEGISLATIVE, JUDICIAL AND PERSONAL EFFORTS TO ELIMINATE RACIAL INEQUALITY, AMERICA IS STILL PLAGUED BY RACISM, AND THERE ARE MANY WHO SEE ETHNIC HOSTILITY AND DISCRIMINATION ONLY INCREASING IN THE YEARS IMMEDIATELY BEFORE US.

DESPITE THE FACT THAT OUR COMMUNITIES ARE MORE CULTURALLY DIVERSE, SOCIAL INSTITUTIONS HAVE NOT ADAPTED TO THESE CHANGES. PROFESSIONAL INSENSITIVITY TO CULTURAL DIFFERENCES AND LANGUAGE BARRIERS IMPEDE ACCESSIBILITY TO SERVICES FOR CULTURALLY DIFFERENT FAMILIES AND ADOLESCENTS.

AS WE KEEP OUR FINGER ON THE PULSE OF THE FAMILY, AS WE ARE SENSITIVE TO CULTURAL DIFFERENCES, WE NEED TO GROUND OUR SERVICES IN THE COMMUNITY.

COMMUNITY-BASED SERVICES ARE THE KEY TO WINNING THE STRUGGLE AGAINST ADOLESCENT HEALTH PROBLEMS.

OUR COUNTRY IS RECOGNIZED INTERNATIONALLY FOR SOPHISTICATED TERTIARY CARE AND TECHNOLOGICAL ADVANCES; YET WE LACK ACCESS AND EQUITY FOR BASIC SERVICES AT THE FAMILY AND COMMUNITY LEVEL. WE ARE THE ONLY DEVELOPED NATION THAT DOES NOT GUARANTEE HEALTH CARE TO EVERY CITIZEN, WITH THE EXCEPTION OF SOUTH AFRICA.

SERVICES NEED TO BE PROVIDED IN OR NEAR THE HOME COMMUNITIES OR NEIGHBORHOODS OF CHILDREN AND THEIR FAMILIES. FAMILIES SHOULD NOT HAVE TO TRAVEL LONG DISTANCES FOR SERVICES. AND WHENEVER POSSIBLE, CHILDREN SHOULD BE CARED FOR AT HOME RATHER THAN IN A HOSPITAL.

I HAVE BECOME CONVINCED THAT FINDING THE RIGHT PLACE FOR ADOLESCENT HEALTH CARE WILL WIN HALF THE BATTLE.

EVEN WHEN ADOLESCENTS DECIDE TO SEEK A PHYSICIAN, FINDING A DOCTOR IS USUALLY A LOST CAUSE FOR MANY OF THEM.

I SPENT MUCH OF MY PROFESSIONAL LIFE MAKING SURE THAT CHILDREN WITH SURGICAL PROBLEMS CONTINUED TO RECEIVE GOOD COMPREHENSIVE CARE IN THE ADULT WORLD, SO I KNOW THAT ONE OF THE PERSISTENT PROBLEMS OF AMERICAN MEDICINE IS THE DIFFICULTY OF TRANSITION BETWEEN PEDIATRIC AND ADULT MEDICAL CARE.

SOME ADOLESCENTS DON'T LIKE TO KEEP GOING TO THEIR PEDIATRICIANS, THE "BABY DOCTOR", AND SOME PEDIATRICIANS ARE GLAD, FROM A PROFESSIONAL IF NOT PERSONAL POINT OF VIEW, TO SEE THEM MOVE ON.

OTHER ADOLESCENTS ARE RELUCTANT TO CHANGE, WHILE SOME PEDIATRICIANS FEEL TOO MUCH OF A PROPRIETARY INTEREST IN THEIR GROWING PATIENTS, AND CLING TO ADOLESCENTS WHO WOULD BE BETTER SERVED IN AN ADULT PRACTICE.

BUT THEN, MANY INTERNISTS WITH AN ADULT PRACTICE ARE NOT THAT ANXIOUS TO TAKE ON ADOLESCENTS AS PATIENTS.

SO, AGAIN THEY FALL THROUGH THE CRACKS.

SERVICES MUST NOT SIMPLY BE IN THE COMMUNITY --AS IMPORTANT AS THAT IS-- THEY MUST ALSO BE COORDINATED

ONE OF THE MAJOR PROBLEMS IN DEALING WITH ADOLESCENT HEALTH NEEDS IS THE PROBLEM OF FRAGMENTED SERVICES.

SO FAR THE RESPONSE OF CONCERNED CITIZENS AND LEGISLATORS HAS BEEN TO SET UP A NUMBER OF PROGRAMS OR SERVICES, EACH DESIGNED TO DEAL WITH A SPECIFIC PROBLEM: AIDS, CHILD ABUSE, TEENAGE PREGNANCY, DRUGS, AND SO FORTH.

BUT THE LACK OF COLLABORATION BETWEEN THESE PROGRAMS CAN BLUNT THEIR SUCCESS, OR EVEN DOOM THEM TO FAILURE. BUREAUCRATIC MYOPIA, RIGID REPORTING PROCEDURES, OVERLY RESTRICTED FUNDING, AND PLAIN INSENSITIVITY TO THE LARGER PICTURE OF THE ADOLESCENT'S WORLD CAN DOOM THE BEST INTENDED PROGRAM.

FRAGMENTATION OF SERVICES CAN LEAD TO BITTER FRUSTRATION.

FOR EXAMPLE, AN ADOLESCENT WHOSE NEEDED MEDICAL CARE IS PAID FOR BY MEDICAID CAN LOSE ELIGIBILITY FOR MEDICAID IF HIS MOTHER GOES TO WORK OR REMARRIES.

OR A TEEN ALCOHOL ABUSER MAY FINISH AN ALCOHOL ABUSE PROGRAM, BUT IN THE MEANTIME HAS TAKEN TO COCAINE, BECAUSE THE PROGRAM HAS NOT TOUCHED THE BASIC BEHAVIORAL PROBLEM.

A TEENAGE MOTHER MAY BE DENIED ENTRY INTO A PARENTING PROGRAM BECAUSE SHE HAS NOT DROPPED OUT OF SCHOOL AND THEN RE-ENROLLED.

A HOMELESS TEENAGER MAY BE DENIED A VARIETY OF SERVICES BECAUSE HE/SHE HAS NO ADDRESS.

SERVICES MUST BE COORDINATED TO BE RESPONSIVE TO ADOLESCENTS AND FAMILIES TO PREVENT GAPS IN SERVICE, AND TO KEEP SERVICES FROM BEING PROVIDED SEPARATELY FROM EACH OTHER.

STRONG LEADERSHIP AND COMMITMENT ARE NEEDED AS PEOPLE AND GROUPS WORK TOGETHER TO IMPROVE DELIVERY OF SERVICES.

THE FURTHER THE ADMINISTRATION OF THE PROGRAMS GET FROM THE LOCAL LEVEL, THE LESS SUCCESSFUL THEY WILL BE. LOCAL GROUPS SEE THE LOCAL PROBLEMS THE MOST CLEARLY.

THEY NEED TO BE GIVEN THE POWER AND THE FUNDS TO DO WHAT NEEDS TO BE DONE FOR THEIR YOUNG PEOPLE. THEY KNOW HOW TO LINK SELF-HELP GROUPS WITH HEALTH PROGRAMS. THEY ARE THE ONES WHO CAN INSURE COLLABORATION WITHOUT BAFFLING COMPLEXITY.

THE PLACE WE NEED THE GREATEST COORDINATION, THE CLOSEST COLLABORATION, IS BETWEEN THE HEALTHCARE SERVICES AND THE SCHOOLS.

THE CLOSE CONNECTION BETWEEN THE PROBLEMS OF ADOLESCENT HEALTH AND THE PROBLEMS OF ADOLESCENT EDUCATION HOLD THE PERIL OF COMMON DESTRUCTION..... OR THE OPPORTUNITY OF JOINT SOLUTION.

THOSE ADOLESCENTS WHO HAVE GOOD HEALTH, A STRONG SELF-IMAGE, WHO ARE PHYSICALLY FIT, WILL BE LESS INCLINED TO RISK A BRIGHT FUTURE BY ENGAGING IN RISKY BEHAVIOR, IN DRUG OR ALCOHOL ABUSE.

BUT THE ADOLESCENT DOING POORLY IN SCHOOL, FACING A DARK FUTURE, MAY READILY SEEK ESCAPE IN DRUGS, ALCOHOL, GANGS, AND THEN OF COURSE, FALL EVEN FURTHER BEHIND.

A MINNESOTA STATE-WIDE STUDY CONFIRMED THAT ADOLESCENTS WITH LOW GRADES IN SCHOOL WERE TWO TO FIVE TIMES MORE LIKELY TO SMOKE DAILY, USE ALCOHOL EXCESSIVELY, BE SEXUALLY PROMISCUOUS, AND ATTEMPT SUICIDE THAN TEENS WITH ABOVE-AVERAGE GRADES. THIS FINDING WAS ACROSS THE BOARD, FOR ALL RACIAL AND ETHNIC GROUPS.

IT IS FOOLHARDY FOR AMERICANS TO BE CONCERNED ABOUT THE AMERICAN SCHOOLS WITHOUT SIMILAR CONCERN FOR THE HEALTH OF AMERICAN SCHOOL CHILDREN AND ADOLESCENTS.

HEALTH AND EDUCATION CAN NO LONGER BE TREATED AS SEPARATE SPHERES.

ALL TOO OFTEN, TODAY, THE SCHOOL NURSE, THE NUTRITION COUNSELOR, THE PHYSICAL EDUCATION PROGRAMS ARE SIMPLY NOT MEETING THE REAL HEALTH NEEDS OF ADOLESCENT STUDENTS.

FOR EXAMPLE SUCCESSFUL "MAINSTREAMING" SPECIAL NEEDS STUDENTS REQUIRES INTENSE COLLABORATION BETWEEN HEALTH AND EDUCATION PERSONNEL.

EDUCATIONAL AND HEALTH SERVICES DEAL WITH MANY OF THE SAME PROBLEMS, SO THEY SHOULD GET THEIR ACTS TOGETHER.

BUT WE NEED SCHOOL-HEALTH COORDINATION NOT ONLY BECAUSE THE PROBLEMS ARE INTERTWINED, BUT ALSO BECAUSE FOR HEALTH SERVICES TO BE REACH ADOLESCENTS THEY MUST BE CONVENIENT TO USE.

AND SINCE SCHOOL IS ONE PLACE THE ADOLESCENT SHOULD BE, IT IS THE BEST PLACE TO LOCATE A PRIMARY HEALTHCARE FACILITY. AND MAYBE HAVING THE SCHOOL AND CLINIC TOGETHER WILL MAKE THE ADOLESCENT MAKE BETTER USE OF EACH.

RIGHT NOW, THINGS DO NOT OPERATE VERY EFFECTIVELY.

AT POLICY AND POLITICAL LEVELS WE HAVE RESPONDED WITH SINGLE ISSUE OR CATEGORICAL PROGRAMS AS EACH HUMAN SERVICE CONCERN IS BROUGHT TO NATIONAL ATTENTION. IN THIS COUNTRY, HEALTH AND EDUCATION SERVICES ARE PROVIDED BY A COMPLEX MIX OF PUBLIC, PRIVATE AND VOLUNTARY AGENCIES AND ORGANIZATIONS.

WE MUST DEVELOP NEW ORGANIZATIONAL RELATIONSHIPS AMONG SCHOOLS, PHYSICIANS, PUBLIC HEALTH AGENCIES AND SOCIAL SERVICE ORGANIZATIONS. IN ADDITION, FEDERAL AND STATE SYSTEMS MUST ALLOCATE NECESSARY RESOURCES AND ESTABLISH CONDITIONS THAT FACILITATE THE DEVELOPMENT OF THESE NEW ORGANIZATIONAL RELATIONSHIPS IN LOCAL JURISDICTIONS.

WE MUST ORGANIZE HEALTH AND EDUCATION SERVICES IN WAYS THAT ACKNOWLEDGE THE COMPLEXITY OF SOCIAL ENVIRONMENTS AND ADDRESS SUCH CONCERNS AS THEY EMERGE.

AS THE NEEDS OF CHILDREN AND FAMILIES EXPAND AND BECOME MORE COMPLEX, IT IS MORE AND MORE APPARENT THAT BOUNDARIES OF PROFESSIONAL RESPONSIBILITY AS REFLECTED IN OUR EXISTING SERVICE DELIVERY SYSTEM ARE OFTEN DYSFUNCTIONAL.

THERE ARE SEVERAL POPULATIONS OF ADOLESCENTS CURRENTLY BEING SERVED INDEPENDENTLY BY HEALTH AND EDUCATION PROVIDERS. INSTEAD, WE MUST MAKE CHANGES IN THE SERVICE SYSTEM THAT ALLOW PROFESSIONALS TO PROVIDE SERVICES TO ADOLESCENTS AND FAMILIES COLLABORATIVELY BECAUSE OF THE CHANGING SOCIAL CONTEXT WHERE ADOLESCENTS COME TO SCHOOL WITH EDUCATIONAL PROBLEMS WHOSE ORIGINS AND SOLUTIONS LIE AS MUCH IN THE AREA OF HEALTH AS IN EDUCATION.

HEALTH AND EDUCATION SERVICE PROVIDERS MUST CREATE CHANGES IN THE EXISTING SERVICE DELIVERY SYSTEM THAT ENABLE EFFECTIVE COLLABORATION.

OUR MANY FRAGMENTED ATTEMPTS TO DEAL WITH THE HEALTH AND EDUCATIONAL PROBLEMS OF ADOLESCENTS HAVE PRODUCED AT LEAST ONE GOOD MODEL OF A COORDINATED PROGRAM. THE SPECIAL EDUCATION EXPERIENCE OF THE LAST TWO DECADES IS ONE EARLY EFFORT TO ENCOURAGE COOPERATION BETWEEN HEALTH AND EDUCATION PROFESSIONALS.

P.L. 94-142 INSURED THE PROVISION OF FREE, APPROPRIATE PUBLIC EDUCATION SERVICES TO CHILDREN WITH SPECIFIC HANDICAPPING CONDITIONS. IT ALSO OUTLINED A PROCESS WHEREBY THESE CHILDREN WOULD, TO THE EXTENT POSSIBLE, BE EDUCATED IN THE LEAST RESTRICTIVE ENVIRONMENT. BECAUSE MANY OF THESE CHILDREN WERE MEDICALLY FRAGILE OR HAD SPECIAL HEALTH NEEDS, HEALTH PROFESSIONALS BECAME INVOLVED IN DESIGNING AND OFTEN IMPLEMENTING INDIVIDUAL EDUCATION PLANS FOR EACH CHILD.

IN EFFECT, THE LEGISLATION MANDATED COOPERATION BETWEEN HEALTH AND EDUCATION PROFESSIONALS,AND SYSTEMS WERE PUT INTO PLACE TO STREAMLINE THIS SERVICE COORDINATION IN WAYS THAT WOULD BEST ADDRESS THE NEEDS OF THIS CATEGORICAL PROGRAM .

P.L. 94–142 DEMONSTRATED THE NEED FOR A BETTER WAY TO COORDINATE A BROAD RANGE OF SERVICES FOR CHILDREN WITH HANDICAPPING CONDITIONS.

WHILE IT DID NOT FORMALLY ENCOURAGE COLLABORATION BETWEEN THOSE WHO PROVIDE HEALTH AND EDUCATION SERVICE, IMPLEMENTORS IDENTIFIED SEVERAL ISSUES RELATED TO SERVICE COORDINATION THAT NEEDED TO BE ADDRESSED IN ORDER TO BETTER SERVE THE TARGETED POPULATION.

FOR THE FIRST TIME IN THE FEDERAL EDUCATION LEGISLATIVE PROCESS, STATES WERE CHALLENGED TO MAKE CHANGES IN EXISTING SERVICE SYSTEMS THROUGH A COORDINATED, MANAGED EARLY INTERVENTION PROCESS.

SOME OF THE MOST CREATIVE EXAMPLES OF COLLABORATION BETWEEN EDUCATION AND HEALTH PROFESSIONALS CAN BE FOUND IN THE EXTENSIVE INTERAGENCY PLANNING PROCESS THAT IS NOW OCCURRING AS STATES CREATE SERVICE DELIVERY SYSTEMS IN LOCAL JURISDICTIONS FOR INFANTS AND TODDLERS WITH HANDICAPS AND THEIR FAMILIES.

IN SUCH A SYSTEM, PUBLIC AND PRIVATE HEALTH, EDUCATION AND SOCIAL SERVICE PROFESSIONALS COORDINATE THEIR SERVICES IN THE INTERESTS OF CHILDREN AND FAMILIES RATHER THAN IN THE INTERESTS OF THE SERVICE SYSTEMS. IN THIS WAY, ADEQUATE RESOURCES ARE GARNERED AND PROVIDERS ARE APPROPRIATELY SUPPORTED AND REIMBURSED.

COORDINATING THE SCHOOLS AND HEALTHCARE SERVICES WILL MEAN SHELVING SOME OLD SUSPICIONS.

ONCE I TRIED TO GET SOME SCHOOL-BASED CLINICS GOING IN MILWAUKEE, BUT IMMEDIATELY RAN INTO OPPOSITION BECAUSE MOST PEOPLE ASSOCIATED SCHOOL-BASED CLINICS EXCLUSIVELY WITH CONTRACEPTION AND PREGNANCY ISSUES. ACTUALLY, GOOD SCHOOL-BASED CLINICS FIND THAT CONTRACEPTION OR PREGNANCY ISSUES AMOUNT TO ONLY 6 PERCENT OF THEIR WORK.

ANOTHER GOOD REASON TO PLACE CLINICS AND SCHOOLS TOGETHER IS THAT IT WILL ENABLE HEALTH CONSULTATIONS TO OCCUR WITH GREATER

CONFIDENTIALITY.

CONFIDENTIALITY IS ESSENTIAL.

THERE IS A PERVASIVE DISTRUST IN THE ADOLESCENT COMMUNITY.

WHEN I WAS FILMING FOR THE TV SPECIAL ON ADOLESCENT HEALTH, I ARRANGED FOR SOME CANDID TALK WITH KIDS IN MINNEAPOLIS. MEETING WITH THEM INVOLVED GOING THROUGH STEPS LIKE THOSE WE SEE IN MOVIES ABOUT THE MAFIA: A RENDEZVOUS IN DINGY RESTAURANTS, ~~LOOKOUTS AT THE DOORS AND WINDOWS~~, AND SUSPICION SO THICK YOU COULD CUT IT WITH A KNIFE.

MY INITIAL GREETING BY ONE OF THESE YOUNGSTERS WAS, "I DON'T TRUST YOU. I DON'T LIKE YOU. YOU WORKED FOR THE GOVERNMENT, SO YOU MUST BE A LIAR."

OBVIOUSLY, DISTRUST OF PUBLIC OFFICIALS MUST BE OVERCOME IF WE EXPECT THE PUBLIC SECTOR TO HAVE A POSITIVE IMPACT UPON ADOLESCENTS AND THEIR HEALTH. ASSURING CONFIDENTIALITY IS ESSENTIAL.

ADOLESCENT FEAR OF LACK OF CONFIDENTIALITY IS A MAJOR REASON WHY THOUSANDS OF ADOLESCENTS AVOID HEALTH CARE FACILITIES.

EVEN THOSE WHO CAN AFFORD MEDICAL CARE BECAUSE THEY ARE COVERED BY THEIR PARENTS' INSURANCE WILL AVOID NEEDED HEALTH CARE IF INSURANCE COVERAGE MEANS A BREACH OF CONFIDENTIALITY.

TRUE, PARENTAL INVOLVEMENT IN ADOLESCENT HEALTH IS IMPORTANT, BUT IT CANNOT BE ALLOWED TO STAND IN THE WAY OF ADOLESCENT HEALTHCARE.

AS IS THE CASE WITH SO MANY PROBLEMS, SOONER OR LATER WE NEED TO TALK ABOUT MONEY.

ADOLESCENT HEALTH CARE MUST BE

ADEQUATELY FINANCED.

ALL ADOLESCENTS NEED TO BE GUARANTEED ACCESS TO HEALTH CARE, REGARDLESS OF ABILITY TO PAY.

IT IS A NATIONAL TRAVESTY TO HAVE SO MANY OF OUR CITIZENS LIVE AMID THE SIGNS OF AFFLUENCE AND OPULENCE, BUT UNABLE TO AFFORD BASIC HEALTH CARE.

FAR TOO OFTEN ACCESS TO HEALTH CARE FOR ADOLESCENTS DEPENDS ON THE FAMILY'S FINANCIAL CIRCUMSTANCES, AND EVEN UPON THE STATE IN WHICH THOSE CIRCUMSTANCES OCCUR.

ABOUT 15 PERCENT OF ALL 10 TO 18 YEAR-OLDS LACK PUBLIC FINANCING OR PRIVATE INSURANCE FOR HEALTH CARE COSTS. IN FAMILIES LIVING UNDER THE POVERTY LEVEL, FULLY 35 PERCENT OF SCHOOL AGE CHILDREN LACK HEALTH INSURANCE.

THERE IS A REAL [redacted] DIFFERENCE BETWEEN BEING INDIGENT AND BEING MEDICALLY INDIGENT. I DOUBT THAT THERE ARE ANY INDIGENT HERE. BUT MANY OF YOU COULD BECOME MEDICALLY INDIGENT DEPENDING ON THE DIAGNOSIS IN YOUR NEXT ADVERSE HEALTH ENCOUNTER.

FOR EXAMPLE, THE POVERTY LEVEL ESTABLISHED BY THE FEDERAL GOVERNMENT FOR A FAMILY OF 3 IS $10,500.

BUT [redacted] STATES, [redacted] DECLARE THAT A PERCENTAGE OF POVERTY LEVEL TO QUALIFY FOR MEDICAID SHALL BE [redacted] OF THE NATIONAL LEVEL.

FOR EXAMPLE [redacted], IF A FAMILY OF THREE IN TEXAS EARNS MORE THAN $3,000 ANNUALLY, THEY ARE TOO RICH FOR MEDICAID.

THIS HAS A DEBILITATING EFFECT NOT ONLY ON HEALTH, BUT ALSO ON MORALE. THOSE AMERICANS IN POVERTY AND ON WELFARE WHO ARE DETERMINED TO WORK THEIR WAY UP, RUN THE RISK OF WORKING THEMSELVES OUT OF POVERTY INTO MEDICAL INDIGENCE. AS THEIR INCOME RISES SLIGHTLY, THEY EARN TOO LITTLE TO LIVE ON, BUT TO MUCH TO GET MEDICAID. MEDICAID IS A MESS, AND IT IS BEGINNING TO COST LIVES, RATHER THAN TO SAVE THEM.

INSURANCE COMPANIES HAVE RESPONDED TO THE CRISIS IN ADOLESCENT HEALTH, AND THE CRISIS IN HEALTHCARE IN GENERAL, IN WAYS THAT SEEM [redacted] UNETHICAL, AND PERHAPS SHOULD BE [redacted] ILLEGAL.

PREMIUMS SUDDENLY GO UP AS SOON AS MEDICAL BILLS COME IN WITH ANY REGULARITY. OLDER ADOLESCENTS SUFFERING A CHRONIC PROBLEM OR DISABILITY OFTEN FIND THEMSELVES UNINSURABLE. AT AGE 22 THEY CAN FIND THEMSELVES DROPPED FROM A PARENTAL POLICY --IF INDEED THEY WERE EVER COVERED-- AND THEN, THANKS TO COMPUTER DATA BANKS, THEY ARE BLACK-LISTED BY ALL INSURANCE COMPANIES, AS UNINSURABLE

WE NEED TO MOUNT PUBLIC PRESSURE AND DIRECT LEGISLATION TO IMPROVE PUBLIC AND PRIVATE INSURANCE. OUR CURRENT SYSTEM OF HODGE-PODGE AND SHELL GAMES IS A NATIONAL DISGRACE.

ALL CHILDREN AND ADOLESCENTS SHOULD HAVE ACCESS TO ADEQUATE HEALTH CARE INSURANCE. IT MUST COVER CHRONIC CARE AND CARE IN THE COMMUNITY.

IT MUST RECOGNIZE THE COMPREHENSIVE NEEDS OF CHILDREN, ADOLESCENTS, AND THEIR FAMILIES.

IT MUST ASSURE EQUAL ACCESS TO CARE FOR ALL ADOLESCENTS ACROSS GEOGRAPHIC BOUNDARIES.

ABOVE ALL, INSURANCE COVERAGE MUST BE BROADENED TO INCLUDE PREVENTIVE PROGRAMS. THAT SAVES MONEY AS WELL AS LIVES.

FINANCING NEEDS TO BE CREATIVE TO ALLOW COLLABORATION BETWEEN THE VARIOUS PROGRAMS AND PERSONS DEALING WITH ADOLESCENT HEALTH.

THE COLD ECONOMIC REALITY IS SIMPLY THIS. IT IS A GOOD INVESTMENT TO SPEND SOME MONEY --BOTH PUBLIC FUNDING AND UNIVERSALLY AVAILABLE AND AFFORDABLE PRIVATE INSURANCE-- RATHER THAN MORE MONEY LATER.

DOLLARS SPENT FOR HEALTHY CHILDREN AND ADOLESCENTS WILL SAVE DOLLARS SPENT ON COSTLY ADULT HEALTH CARE LATER.

IT IS GOOD COMMON SENSE AND GOOD BUSINESS SENSE TO RAISE A HEALTHY YOUNGER GENERATION, BUT IT HAS NOT BEEN GOOD POLITICS.

YOUNG PEOPLE SUFFER FROM GOVERNMENT INATTENTION BECAUSE THEY DON'T VOTE, AND THEY HAVE NO LOBBY TO REPRESENT THEIR INTERESTS. SO GOVERNMENT HAS PROVEN RELUCTANT TO SPEND FOR THE HEALTH OF CHILDREN AND ADOLESCENTS, EVEN THOUGH THE LONG TERM BENEFITS AND SAVINGS OUTWEIGH THE IMMEDIATE SHORT TERM EXPENDITURES.

WE NEED TO CHANGE THAT SHORT SIGHTED THINKING.

WE MIGHT LEARN AT LEAST A LITTLE SOMETHING FROM RECENT BOONDOGGLES LIKE THE S&L CRISIS, THAT CONFRONTING A PROBLEM EARLY CAN AVOID BIGGER AND MORE COSTLY PROBLEMS LATER ON.

I FEAR THAT THE ADMINISTRATION AND CONGRESS WILL NOT ADDRESS THE ISSUE OF ADOLESCENT HEALTH ON THE CLEAR MERITS OF THE SITUATION --IN SPITE OF THE NATION'S AFFLUENCE AND PROSPERITY. THE DAY WILL COME WHEN THE BUSINESS COMMUNITY WILL EXERT GREATER PRESSURE FOR MORE REALISTIC FUNDING OF HEALTH CARE. WE MUST MAKE SURE THAT ADOLESCENTS ARE NOT LEFT OUT.

FORTUNATELY SOME INDIVIDUALS AND CORPORATIONS, NOT JUST HUMAN SERVICE ORGANIZATIONS, ARE SEEING THE COMPELLING NEED TO INVEST IN THE HEALTH OF OUR CHILDREN AND ADOLESCENTS, ...AN INVESTMENT IN THEIR HEALTH, NOT JUST IN THE TREATMENT OF DISEASE.

WE NEED MAJOR CHANGES IN THINGS THAT ARE HARD TO CHANGE: SOCIAL INSTITUTIONS AND PROFESSIONAL PRACTICES.

THE TASK BEFORE US IS DIFFICULT.

BUT SO ARE MANY OF THE TASKS DISCUSSED IN LECTURES BEFORE THIS DISTINGUISHED AUDIENCE.

WE ARE HERE BECAUSE WE ARE CONCERNED.

WE ARE HERE BECAUSE WE BELIEVE IN THE ABILITY TO TRANSLATE THE BEST OF THE SPIRIT OF MAN INTO ACTION, INTO CHANGE.

LIFE AFFORDS NO GREATER RESPONSIBILITY, NO GREATER PRIVILEGE THAN THE RAISING OF THE NEXT GENERATION.

TO BE TRUE TO THE SPIRIT OF THE SPIRIT OF MAN, I CALL UPON YOU, UPON US ALL TO MAKE A FOCUSED COMMITMENT TO MEET THE HEALTH NEEDS OF THIS NEGLECTED SEGMENT OF OUR SOCIETY, OUR ADOLESCENTS.

NOW, THERE IS ONE MORE POINT I SHOULD MAKE IF WE ARE GOING TO BE HONEST WITH OURSELVES IN DEALING WITH THESE PROBLEMS OF ADOLESCENT HEALTH.. . . . IF WE ARE GOING TO DEAL WITH THESE PROBLEMS, NOT IN A THEORETICAL OR RHETORICAL WAY, PUT IN A DOWN-TO-EARTH, PRACTICAL, AND PERSONAL WAY.

THE ISSUE SIMPLY STATED IS THIS:

ADOLESCENTS ARE NOT THE EASIEST PEOPLE TO DEAL WITH.

MANY ADULT AMERICANS ARE SIMPLY NOT DRAWN TO AWKWARD, ABUSIVE ADOLESCENTS. THEIR ATTITUDES AND BEHAVIOR CAN PUT OTHER PEOPLE OFF. AND, IN SPITE OF THE POWER OF PEER PRESSURE, ADOLESCENTS OFTEN DON'T ADMIRE EACH OTHER. THEY FIND FEW ROLE MODELS AMONG THEMSELVES. AND THE ONES THEY DO FIND OFTEN LEAD THEM DOWN THE WRONG PATH.

BUT THE PICTURE NEED NOT BE SO BLEAK. THERE ARE MANY HEROS AMONG OUR ADOLESCENT POPULATION. IT'S TIME WE GAVE THEM THEIR DUE, IT'S TIME WE LET THEM DO WHAT THEY CAN DO AS ROLE MODELS FOR OTHER ADOLESCENTS.

TWO OF MY GREATEST HEROS, PEOPLE OF REAL INSPIRATION ARE ADOLESCENTS. THEY CARRY ALL THE EMOTIONAL BURDENS NORMAL TO ADOLESCENTS, BUT THESE TWO FELLOWS CARRY MORE, MORE THAN I COULD BEAR.

PAUL AND CHRISTOPHER HAVE BEEN AN INSPIRATION TO ME, AND TO COUNTLESS OTHERS, ADULTS, ADOLESCENTS, AND CHILDREN. PAUL AND CHRISTOPHER HAVE LIVED ALL THEIR LIVES WITH PROBLEMS THAT WE "NORMAL" PEOPLE LABEL AS " DISABILITIES."

BUT THEIR DETERMINATION, THEIR RESILIENCE, THEIR POSSESSION OF THE BEST OF THE SPIRIT OF MAN MADE ME ASK MANY TIMES

"WHO ARE THE TRULY DISABLED AMONG US?"

THERE WERE ~~BEEN~~ MANY TIMES DURING MY CAREER AS A PEDIATRIC SURGEON, WHEN I HAD TO PUT ASIDE MUCH OF THAT EXPERIENCE AND THAT RHETORIC -- WHAT MIGHT BE CALLED THE "CONVENTIONAL WISDOM" OF DISABILITY.

PAUL CERTAINLY MADE ME DO THIS. NOT LONG AGO PAUL GRADUATED FROM HIGH SCHOOL, IN [redacted]. HE FINISHED WITH A VERY GOOD ACADEMIC RECORD...HE WAS ALSO ON THE VARSITY BASKETBALL TEAM. AND HE WAS CLASS VALEDICTORIAN. A RATHER GOOD RECORD, I WOULD SAY.

BUT I THINK THE "CONVENTIONAL WISDOM" OF DISABILITY WOULD PROBABLY HAVE WRITTEN PAUL OFF MANY YEARS AGO.

PAUL IS A GRADUATE NOT ONLY OF SECONDARY SCHOOL -- BUT OF 62 OPERATIONS, EACH OF THEM DIFFICULT, EACH OF THEM NECESSARY, EACH OF THEM A TERRIBLE, TRAUMATIC INTERRUPTION IN THE LIFE OF A GROWING BOY.

I KNOW ABOUT THESE OPERATIONS BECAUSE I PERFORMED 37 OF THEM.

BUT PAUL SURVIVED THEM ALL -- AND THE GROWING PAINS OF ADOLESCENCE, TOO -- AND TODAY HE IS A STRONG, DECENT, BRIGHT YOUNG MAN, A COLLEGE GRADUATE HOLDING DOWN A RESPONSIBLE JOB.

I'LL MAKE A CONFESSION RIGHT HERE AND ADMIT THAT I DON'T REALLY KNOW HOW HE DOES IT. BUT THROUGH THE YEARS HE HAS ABSORBED THE SHOCK OF REPEATED OPERATIONS.

HE HAS ABSORBED THE HIGHS OF LOVING, TENDER CARE AND THE LOWS OF REJECTION.

YEAR AFTER YEAR HE HAS HAD TO ABSORB A GREAT DEAL OF INFORMATION ABOUT HOW TO GO ON LIVING DURING THE MASSIVE RECONSTRUCTIONS BEING DONE TO HIS FACE AND HIS BODY.

WE WOULD CALL HIM A "DISABLED, HANDICAPPED" CHILD. BUT PAUL...SO COURAGEOUS AND SO VERY INNOCENT... HAS REFUSED TO BE DISABLED AND HANDICAPPED. AND SO HE HAS ENDED THIS CHAOTIC AND PAINFULLY LONG PERIOD OF CHILDHOOD, PUBERTY, AND ADOLESCENCE AS AN IMPORTANT YOUNG MAN.

I COULD NOT HAVE DONE IT. I KNOW VERY FEW PEOPLE WHO COULD. I THINK MOST OF US ARE TOO "DISABLED" IN FAITH OR IN SPIRIT OR IN COURAGE TO HAVE GONE THROUGH SUCH AN ORDEAL OF PHYSICAL AND EMOTIONAL RECONSTRUCTION.

NO, THE ONLY PERSON WHO COULD HAVE SUCCESSFULLY WEATHERED THE YEARS OF REPEATED SURGICAL ASSAULT IS, OF COURSE...PAUL HIMSELF. HE HAS THE ABILITY. AND I AM VERY, VERY PROUD TO CALL HIM MY FRIEND.

BUT LET ME ADD JUST A WORD ABOUT HIS FAMILY.

SOME YEARS AGO, WHEN PAUL WAS ABOUT TWO-THIRDS THE WAY THROUGH HIS LONG SURGICAL ORDEAL, I WAS ASKED BY A CANADIAN UNIVERSITY TO DELIVER A LECTURE ON A TOPIC RELATED TO PAUL'S EXPERIENCE. I APPROACHED PAUL'S MOTHER AND ASKED HER FOR ANY OBSERVATIONS SHE MIGHT WANT TO MAKE. FOR EXAMPLE, I ASKED HER, "WHAT WAS THE WORST THING THAT HAS EVER HAPPENED TO YOU IN YOUR LIFE?"

AND SHE ANSWERED, "HAVING OUR SON BORN WITH ALL THOSE DEFECTS THAT REQUIRED 37 OPERATIONS TO CORRECT."

I WASN'T SURPRISED BY HER ANSWER. BUT I ALSO KNEW SHE HAD A STRONG FAMILY, A DEVOTED HUSBAND, AND THREE OTHER CHILDREN WHO WERE BORN HEALTHY AND HAVE BEEN LOVING SIBLINGS TO HER SON. SO I ASKED HER, "ALL RIGHT, WHAT WAS THE BEST THING THAT EVER HAPPENED IN YOUR LIFE?"

AND SHE ANSWERED, "HAVING OUR SON BORN WITH ALL THOSE DEFECTS THAT REQUIRED 37 OPERATIONS TO CORRECT."

LET ME TELL YOU ANOTHER STORY ABOUT AN ADOLESCENT, ANOTHER FORMER PATIENT OF MINE.

THIS ONE IS ABOUT A YOUNG MAN NAMED CHRISTOPHER. I MET LITTLE CHRISTOPHER ABOUT 20 YEARS AGO WHEN HE WAS ONLY 4 DAYS OLD. AND HE WAS A MESS.

A MAJOR GASTROINTESTINAL DEFECT

HE HAD N[redacted]. AND HE WAS A FLOPPY BABY. HE LOOKED LIKE HE MIGHT BE MILDLY RETARDED. THREE OTHER PHYSICIANS HAD DECIDED THAT CHRISTOPHER WOULD NOT BE WORTH THE EFFORT AND THE COST OF REPARATIVE SURGERY. AND THEY TOLD CHRISTOPHER'S MOTHER SOMETHING THAT NOBODY CAN EVER PREDICT: THAT IS, THE KIND OF LIFE A CHILD IS GOING TO HAVE.

CHRISTOPHER HAD A LEARNING DISABILITY. FROM THE VERY BEGINNING, HE NEEDED A LOT OF HELP AND A LOT OF LOVE. AND HE GOT BOTH.

CHRISTOPHER'S FAMILY HAD STARTED OUT PRETTY MUCH LIKE MOST AMERICAN FAMILIES. REALLY, I THINK YOU CAN MEET PEOPLE LIKE HIS MOTHER AND FATHER ALMOST EVERY DAY ANYWHERE IN THIS COUNTRY.

BUT THEY HAVE A SPECIAL ADVANTAGE: THEY'VE HAD CHRISTOPHER.

CHRISTOPHER HAS TAUGHT THEM A GREAT DEAL ABOUT LIFE. AS A DISABLED CHILD, THEN AS A DISABLED ADOLESCENT HE MADE THE REST OF HIS FAMILY...

ABLE TO CARE DEEPLY ABOUT EACH OTHER...

ABLE TO GIVE EACH OTHER GENUINE, UNABASHED LOVE AND AFFECTION...

AND MADE THEM ABLE TO EXTRACT FROM THEIR OWN HEARTS AND SPIRITS THE FINEST, PUREST INSTINCTS OF HUMANITY

CHRISTOPHER BROUGHT ABOUT AN EXTRAORDINARY CHANGE IN THE LIFE OF THIS OTHERWISE ORDINARY FAMILY. HE HAD ENRICHED IT SO, THAT HIS FAMILY MADE A MOMENTOUS DECISION. THEY MOVED TO A LARGER HOUSE ON A FARM OUTSIDE OF TOWN AND ADOPTED 12 MORE RETARDED CHILDREN. THEY BROUGHT THOSE KIDS INTO A SNUG, LOVING HOME, WHERE EVERYONE GROWS UP WITH A RATHER SPECIAL, RATHER PRECIOUS ABILITY TO CARE VERY DEEPLY ABOUT THE PEOPLE SITTING ON THEIR RIGHT AND THEIR LEFT.

WHEN CHRISTOPHER ENTERED ADOLESCENCE HE JOINED THE BOY SCOUTS. HE TOLD ME ABOUT IT DURING A VISIT TO MY OFFICE AT THE CHILDREN'S HOSPITAL OF PHILADELPHIA. HE SAID THAT HE HAD A GREAT AMBITION. HE HOPED ONE DAY TO BE AN EAGLE SCOUT.

YOU SEE, CHRISTOPHER DID NOT REALLY ACCEPT THE FACT THAT HE WAS A DISABLED ADOLESCENT WITH LIMITATIONS ON HIS PERSONAL LIFE AND AMBITIONS.

I SAID, "CHRISTOPHER, I'M TICKLED THAT YOU'VE JOINED THE SCOUTS. AND I WANT YOU TO PROMISE TO TELL ME WHEN YOU BECOME AN EAGLE SCOUT. I WANT TO BE THERE WHEN YOU GET YOUR BADGE.

HE PROMISED HE WOULD TELL ME. AND HE DID

A FEW YEARS LATER I WENT FROM WASHINGTON TO MY HOME TOWN [redacted] TO A LITTLE CEREMONY IN WHICH I PINNED THE EAGLE SCOUT BADGE ON MY FRIEND CHRISTOPHER. HE STOOD ON THE STAGE AND THANKED HIS PARENTS, HIS SCOUTMASTER, HIS DOCTOR, HIS FIVE HEALTHY, NORMAL SISTERS, AND HIS 12 ADOPTIVE BROTHERS AND SISTERS. HE THANKED US ALL FOR THE HELP AND ENCOURAGEMENT WE'D GIVEN HIM SO THAT HE COULD ACHIEVE HIS AMBITION OF BEING AN EAGLE SCOUT. I THOUGHT WE ALL SHOULD HAVE THANKED HIM.

CHRISTOPHER WAS A TEXTBOOK EXAMPLE OF A "DISABLED, HANDICAPPED" ADOLESCENT. OF COURSE, IT'S OUR TEXTBOOK...NOT HIS. AND THANK GOODNESS FOR THE DIFFERENCE.

THESE TWO YOUNG PEOPLE -- PAUL AND CHRISTOPHER -- ARE JUST TWO OF A LARGE NUMBER OF DISABLED CHILDREN AND ADOLESCENTS THAT I'VE HAD THE PRIVILEGE TO KNOW AND TO HELP DURING MY PROFESSIONAL LIFE IN MEDICINE.

THEY ARE ALL VERY SPECIAL PEOPLE TO ME. THEY WERE ALL BROUGHT TO ME BECAUSE THEY WERE IN SOME WAY HURT OR DAMAGED OR INCOMPLETE. THEY WERE, IN THE EYES OF MEDICINE AND SOCIETY, TOO,

DISABLED...HANDICAPPED...IMPERFECT...DIFFICULT... THE SAME TERMS SEEM TO BE APPLIED BY SOCIETY AT ONE TIME OR ANOTHER TO ALL ADOLESCENTS.

BUT I'VE LEARNED IMPORTANT THINGS FROM EVERY ONE OF THEM. AND I'VE HAD TO ASK MYSELF, "JUST HOW COMPLETE AND ABLE AND PERFECT AM I, IF THEY CAN TEACH ME SO MUCH ABOUT THE WONDER OF LIFE?" AND THE ANSWER IS QUITE HUMBLING, WHICH IS A REACTION NOT COMMONLY FOUND AMONG SURGEONS.

NOW, THERE IS A DANGER IN ROMANTICIZING ILLNESS AND DISABILITY. THAT'S NOT A HEALTHY THING TO DO. AND I HOPE YOU DON'T THINK THE STORIES OF MY TWO YOUNG FRIENDS WERE ROMANTIC OR FANCIFUL. THEY AREN'T. QUITE THE OPPOSITE. THEY ARE VERY REAL YOUNG MEN.

THE WAY THESE ADOLESCENTS TRIUMPHED OVER DISADVANTAGE AND DISABILITY MADE ME ASK AGAIN "WHICH OF US IS DISABLED?"

IS IT THE YOUNG MAN WITH THE MUSCULAR DYSTROPHY WHO RESOLUTELY NEGOTIATES THE SCHOOL HALLWAYS AND STAIRS SO AS NOT TO BE LATE FOR ANYTHING? OR IS IT THE THERAPIST WHO SEES THAT YOUNG MAN ONLY AS A DISABLED VICTIM OF THE DISEASE.

IS IT THE MILDLY RETARDED YOUNG WOMAN WHO IS IN PERPETUAL MOTION, CONSTANTLY DOING A HUNDRED-AND-ONE LITTLE CHORES FOR HER FAMILY AND FRIENDS. OR IS IT HER TEACHER WHO METICULOUSLY CONCENTRATES ONLY ON A HANDFUL OF BASIC SKILLS.

IS IT THE TEENAGER WITH IMPAIRED VISION, NEARLY BLIND, BUT STRUGGLING TO LEARN PIANO? OR IS IT THE NEIGHBOR WHO SAYS SHE CAN'T PUT UP WITH THE NOISE FOR ONE MORE DAY?

I SUPPOSE IT WOULD BE NICE TO BE ABLE TO SAY THAT I CAME HERE ~~THIS EVENING~~ TODAY TO DELIVER A BRAND-NEW MESSAGE. BUT I CAN MAKE NO SUCH CLAIM. MY MESSAGE IS REALLY VERY OLD. THE TEXT IS FROM THE ETHICS OF ARISTOTLE, WHO MADE THIS LITTLE OBSERVATION SOME 2400 YEARS AGO. I DON'T ALWAYS AGREE WITH ARISTOTLE, BUT I'LL NEVER QUIBBLE ON THIS OBSERVATION:

"THE NATURE OF MAN," ~~HE~~ ARISTOTLE SAID, "IS NOT WHAT HE WAS BORN AS, BUT WHAT HE WAS BORN FOR."

AS MORE AND MORE OF OUR ADOLESCENTS ARE ALL TOO READILY DISMISSED FOR WHAT THEY WERE BORN AS, WE NEED TO EMPLOY THE BEST OF THE HUMAN SPIRIT, BREATHED INTO US BY GOD, TO SEE THAT THEY CAN BECOME ALL THAT THEY WERE BORN FOR.